

DOCUMENT RESUME

03369 - (A2233370]

The Well-Being of Older People in Cleveland, Ohio. August 9, 1977. 13 pp. + 3 enclosures (3 pp.).

Testimony before the House Select Committee on Aging; by Walter C. Herrmann,, Jr., Regional Manager, Field Operations Div.; Regional Office (Detroit).

Issue Area: Income Security Programs: Programs for Special Target Populations (1304).

Contact: Field Operations Div.: Regional Office (Detroit).

Budget Function: Education, Manpower, and Social Services: Social Services (506); Income Security: Public Assistance and Other Income Supplements (604).

Organization Concerned: Department of Health, Education, and Welfare.

Congressional Relevance: House Select Committee on Aging.

Studies have been conducted to assess the well-being of older people in Cleveland, Ohio, in terms of their social and economic status, mental and physical health, and ability to perform daily tasks. Data were collected on services provided to older people in Cleveland in an effort to identify the effects the programs have had and are having on the lives of older people. Findings/Conclusions: Only one of every five older people in Cleveland whose well-being was assessed was not impaired, while about 23% were generally impaired or worse, including 7% who were considered extremely impaired. Some older people who could benefit from medical services had not received them, while many others who were not impaired in physical health were receiving medical services, apparently as a preventive measure. Most of the people receiving social/recreational services were not assessed as being impaired socially. Although most neighborhoods with a high agency service level were located in the low-income, inner portion of the city, many of the older people living in the higher income neighborhoods have both low income and an assessed well-being that indicates they could benefit from services. Many older people were found to be eligible for Federal programs, but were not using the services from programs for which they were eligible. The data suggest that older persons may be willing to accept certain types of services and not others. (SC)

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UNITED STATES GENERAL ACCOUNTING OFFICE

Washington, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 1:30 p.m., EST
August 9, 1977

*Hearing to be held in
Brooklyn, Ohio

STATEMENT OF
WALTER C. HERRMANN, JR., REGIONAL MANAGER
DETROIT REGIONAL OFFICE
BEFORE THE
SELECT COMMITTEE ON AGING
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE WELL-BEING OF OLDER PEOPLE
IN CLEVELAND, OHIO

Madam Chairman, we welcome the opportunity to discuss the results of our first phase report on the well-being of older people in Cleveland and to briefly describe what we hope to accomplish during the second phase of our study. Our main purpose today is to describe the methodology we are using to determine how a large number of programs affect older people.

STUDY METHODOLOGY

About 20 million people--1 of every 10 Americans--are 65 years old or older. They receive billions in retirement funds and are assisted by over 134 Federal programs. How these programs affect their lives is a question that confronts the Congress each time legislation related to older people is considered.

In attempting to answer the question, we sampled people in Cleveland who were 65 years old and older and were not in institutions, such as nursing homes. Sixteen hundred and nine older people were interviewed by Case Western Reserve University personnel from June through November 1975, using a questionnaire developed by a multidisciplinary team at the Duke University center in collaboration with the Administration on Aging, the former Social and Rehabilitation Service, and the Health Resources Administration of HEW. The questionnaire contains questions about an older person's status in five areas of functioning--(1) social, (2) economic, (3) mental, (4) physical, and (5) activities of daily living.

The older person's responses to questions during the interview were used to categorize his or her status in each of the five areas as one of the following: excellent, good, mildly impaired, moderately impaired, severely impaired, or completely impaired. For example, an older person's physical health status was placed in the appropriate category on a scale ranging from excellent physical health to completely physically impaired.

Thus, the questionnaire responses show a separate status for the five areas of human functioning. However, we wanted to consider the entire person, or what we have defined as the "well-being" of the person. Therefore, we combined the status in each of the five areas to form eight overall well-being groupings. Thus, an older person's overall well-being status was placed in the appropriate grouping on a scale ranging from unimpaired (excellent or good in all five areas of human functioning) to extremely impaired (mildly or moderately impaired in four areas and severely or completely impaired in the other, or severely or completely impaired in two or more areas).

We also identified those factors affecting the well-being of older people. In so doing, we (1) developed specific definitions of services being provided to older people and a technique for quantifying the services; (2) identified the providers of the services--families and friends, Medicare and Medicaid, and over 100 social service agencies; and (3) obtained information about the services provided to each person in our sample and the source and intensity of that service during our interviews with the older people and from the records of the agencies and Medicare and Medicaid.

All of the above data was collected so that it could be related to an individual in our sample. This included the questionnaire data, the data on the services provided, and the services provided through the Medicare and Medicaid programs. By relating data to the individual, we were able to do compara-

tive analyses of sampled older people for over 500 different variables.

We used a variety of statistical analysis techniques to identify those factors that could be affecting the well-being of older people and to explore certain issues relating to programs for older people. These techniques included, among others, multiple regression analysis, factor analysis, and comparative analysis.

Case Western Reserve University has reinterviewed the sample population of older people to identify changes in their status of well-being over the year. Also, we have again gathered data on services provided. After collecting and analyzing this information in the second phase of our study, we will report on (1) the changes in well-being over a 1-year period and (2) the factors influencing those changes. This should help to identify the effects the programs have had and are having on the lives of older people and what could be done by the Congress, and the executive branch, State and local governments, and others to improve older people's lives.

RESULTS OF THE STUDY'S FIRST PHASE

Now I would like to discuss some of the results we obtained from the first phase of our study.

Only one of every five older people in Cleveland whose well-being we assessed was not impaired. Conversely, about 23 percent were generally impaired or worse including 7 percent considered

extremely impaired. (Attachment I shows our projections of the number of older people in Cleveland by assessed well-being.)

A person's assessed well-being is the result of some characteristics which assistance cannot change (like age) and some which assistance can change (like income). Our study showed that unchangeable characteristics associated with well-being were age and race--the younger a person was, the less likely he or she was to be impaired and whites were less likely to be impaired than blacks.

Changeable characteristics associated with well-being were income and education. Our analysis showed that older people with more income were less likely to be impaired, as were those with more education.

Our study also provided information on services provided to older people. The following are examples of the data we developed in the first phase. In the second phase, we will assess the impact of services on the well-being of older people in our sample.

Our data indicated that some older people who could benefit from medical services had not received them while many others who were not impaired in physical health were receiving medical services, apparently as a preventive measure. For example, about 5.7 percent of our sample were impaired in physical health and did not receive medical services. About 25.8 percent of our sample were not impaired in physical health and were receiving medical services.

We are unable at this time to determine whether the medical services had an effect on the physical health of the sampled older people. In the second phase we will attempt to determine whether changes in physical health over time can be attributed to medical services.

Most older people receiving social/recreational services, 82 percent, were not assessed as being impaired socially. Data from the second phase will enable us to determine whether (1) most people are unimpaired socially when they first obtain social/recreational services or (2) people who are impaired socially when they enter social/recreational services improve as a result of the services.

Our study also included looking at how services are delivered by the many programs designed to help older people. I will briefly describe the results of this portion of our study.

Sources of help

Over \$74 million was spent in Cleveland in 1975, including \$58.6 million for health services under Medicaid and Medicare and subsistence under Supplemental Security Income. The remaining \$15.7 million, was spent by 118 social service agencies.

The 1975 annual funding level of most of these social service agencies was less than \$100,000. Of the 118 agencies, 92 (78 percent) received less than \$100,000 each in Federal funds annually.

Many of these agencies provide similar services. For example, the most offered services are information and referral

(77 agencies), transportation (63), social/recreational (61), escort (51), and outreach (43). (Information on the number of agencies providing each service is shown in Attachment II.)

Opportunities for centralizing the administration of services are apparent, considering the number of agencies providing similar services. Particular services which may by their nature lend themselves to consolidation and centralization of administration include four of the five most-offered services--information and referral, transportation, escort, and outreach.

A large source of service for many older people is their family and friends--9 of every 10 people sampled received some service from their families or friends. For the most part, home help types of service and transportation were provided by the family or friends. Medical and social/recreational services were provided mostly by agencies. Assessment and referral services (which includes information and referral) and financial assistance were split about evenly between family and friends and an agency. (Attachment III shows the percent of sampled people receiving each individual service by source.) Eighty-seven percent of the older people sampled said they had a primary source of help if he or she became sick or disabled.

Location of services

The availability of agency services in a neighborhood could be affecting receipt of services. Older people who lived in neighborhoods served by few agencies received considerably fewer

services than those living where many agencies provided services. Further, the family and friends of older people are apparently not compensating for the unavailability of services.

Most neighborhoods with a high agency service level were located in the low-income, inner portion of the city. Those with a very low service level were mostly in the higher income areas of the city. Thus, it appears that many agencies have focused on the low-income neighborhoods with the idea that low-income older people could benefit most from services.

However, many older people living in higher income neighborhoods have both low income and an assessed well-being that indicates they could benefit from services. To illustrate, there are a projected 4,750 older people who have annual incomes of less than \$3,000 living in neighborhoods with a very low service level, compared to only a few more--a total of 5,000--in neighborhoods with a high service level. Also, there are a projected 4,050 people with an assessed well-being of generally impaired or worse living in neighborhoods with a very low service level, compared to 2,960 in the high service level neighborhoods.

Older people living in public housing are much more likely to receive multiple services from an agency than older people who own their homes or rent. More than half (58 percent) of those in public housing who were generally impaired or worse received three or more services from an agency compared to only 5 percent of those not in public housing. About 9 percent of our sample, a projected 5,718 older people in Cleveland, are

not living in public housing but could benefit from multiple services and are not receiving them. Conversely, many older people in public housing may not need multiple services-- 27 percent of our sample who lived in public housing, a projected 1,284 people, were unimpaired or only slightly impaired.

Eligibility

Many older persons in our sample had income low enough to be eligible for Federal programs. Although eligible, many were not using the services from these programs even though their low income indicates they could benefit from some services.

Using our sample and applying the income criteria for four Federal programs, we determined that more than half of those eligible were not using three programs and 29 percent were not using a fourth program.

Homeowners not receiving financial help

Our study also showed that older people who own their homes are much less likely to be receiving financial services, either from their family and friends or from an agency, than those who rent. Of those with less than \$2,000 income, only 46 percent of the homeowners received financial services, compared to 87 percent of the renters. Also, of those with income between \$2,000 and \$4,000, only 12 percent of the homeowners received financial services, compared to 57 percent of the renters.

Recognized need for help

Older persons' responses to the questionnaires indicate recognition that they could benefit from certain services but do not see the benefit of others. The data suggests that older people may be willing to accept certain services and not others and that outreach efforts may have to be designed accordingly.

Generally, older people who might benefit, as indicated by their responses, from a home help type of service did express a need for one or more of such services. But, older people who might benefit from social/recreational services and mental health services (including psychotropic drugs) generally did not express a need for them. Only about half of those who might benefit from financial services expressed a need.

Assessment and referral aids in using other services

Our data indicates that older people who receive assessment and referral services are more likely to receive other appropriate services. Considering only those who were generally impaired or worse, 56 percent of those who received assessment and referral services received four or more other service types, compared to only 40 percent of those who did not receive assessment and referral services.

Impaired older people do not receive social/recreational services

Older people who were impaired in any of the five functional areas were less likely to receive social/recreational services

than those who were unimpaired. The level of impairment could also make a difference. To illustrate, only 8 percent of those who were severely or completely impaired in active daily living received social/recreational services, compared to 26 percent of those who were mildly or moderately impaired, and 33 percent of those who were unimpaired (good or excellent).

The above indicates that older people who are impaired in any functional area may have problems in taking part in social/recreational services. For example, socially impaired older people may have certain characteristics that make them difficult to locate and/or difficult to communicate with.

PHASE II OF STUDY

We are currently analyzing all the data accumulated during the course of our study. At the conclusion of our analysis, we will report on the changes in the well-being of our sample population over a 1-year period, what may have contributed to those changes, and what can be done to improve older people's well-being.

It would be premature at this time to speculate on what specific conclusions and recommendations our second report will contain. I would, however, like to discuss some of the matters we will be considering during our analysis.

As previously discussed, two changeable characteristics which appeared to affect an older person's well-being were income and education. In the second phase of the study, we will examine the changes in well-being of low-income people

over the year. At that time, we will attempt to determine to what extent the lack of income may have contributed to a decline in well-being. We will also see if older people with more education maintain their well-being or decline less rapidly than those with less education and explore the reasons why this occurs; from this, programs may be designed to help older, less educated people cope with the problems of aging.

A major portion of the second phase of our study will be to assess the impact of services on the well-being of older people in our sample. We will attempt to attribute changes in assessed well-being to services and project the number of older people not receiving services who could benefit from them. For example, at the conclusion of the first phase of our study, we were unable to determine whether medical services had an effect on the physical health of the sampled older people. In the second phase we will attempt to identify whether changes in physical health over time can be attributed to medical services.

If we find in the second phase that (1) older people who were unimpaired in physical health and received medical services generally did not become impaired and (2) those not receiving medical services generally did become impaired, outreach efforts should be redirected toward older people who are not impaired in physical health and are not receiving medical services. This latter group represents an estimated 15.5 percent of the population of older people in our sample.

If we find that older people who were impaired in physical health and received medical services generally fared better over the year than those not receiving medical services, outreach efforts should be redirected to those persons in the latter group, who make up about 5.7 percent of the population of older people.

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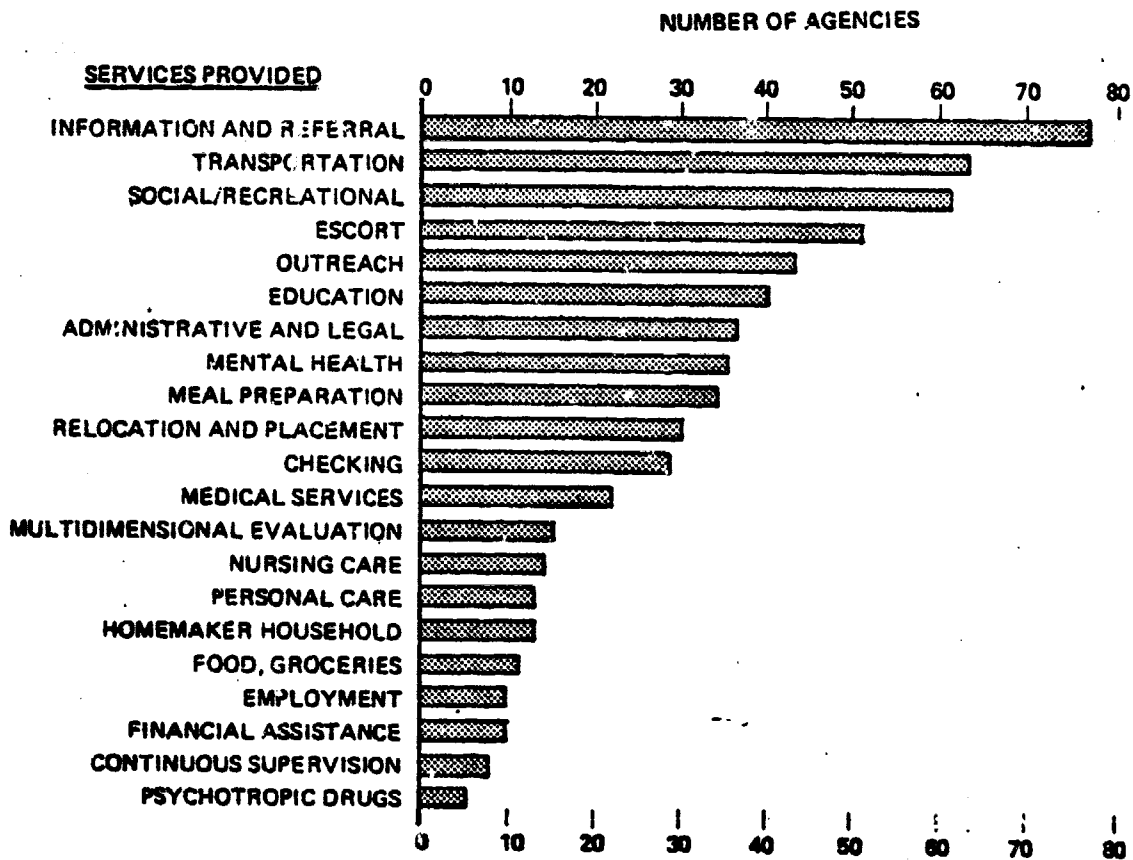
Madam Chairman, that concludes our statement. We will be happy to answer any questions that you may have.

PROJECTIONS OF THE NUMBER OF OLDER PEOPLE
IN CLEVELAND BY ASSESSED WELL-BEING

<u>Assessed well-being</u>	1975 estimate of people 65 and over	
	<u>Number</u>	<u>Percent</u>
Unimpaired	13,400	21
Slightly impaired	13,200	21
Mildly impaired	11,500	18
Moderately impaired	10,300	17
Generally impaired	5,700	9
Greatly impaired	1,900	3
Very greatly impaired	2,300	4
Extremely impaired	4,300	7
Total	<u>a/ 62,600</u>	<u>100</u>
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a/Total does not include all older people in Cleveland because the projections are based on only those who responded during interviews and does not include those in institutions.

NUMBER OF AGENCIES IN CLEVELAND
PROVIDING VARIOUS SERVICES TO
OLDER PEOPLE



NOTE: Seven services provided by fewer than five agencies are not shown. Also, most agencies provided more than one service.

PERCENT OF SAMPLED PEOPLE RECEIVING
INDIVIDUAL SERVICE BY SOURCE

<u>Medical services</u>	<u>Source</u>			<u>Total</u>
	<u>Family/ friends</u>	<u>Agency</u>	<u>Both</u>	
	----- (Percent) -----			
Medical care	-	75	-	75
Psychotropic drugs	-	20	-	20
Supportive devices	-	15	-	15
Nursing care	3	3	1	7
Physical therapy	-	4	-	4
Mental health	-	3	-	3
<u>Home help services</u>				
Personal care	56	1	1	58
Checking	44	1	1	46
Homemaker	20	5	1	26
Administrative and legal	15	7	1	23
Meal preparation	13	8	1	22
Continuous supervision	6	1	1	8
<u>Financial assistance</u>				
General financial	2	7	-	9
Housing	12	10	-	22
Groceries and food stamps	7	8	-	15
<u>Assessment and referral</u>				
Coordination, information, and referral	8	3	1	12
Overall evaluation	-	8	-	8
Outreach	-	5	-	5
Social/recreational (formal, organized activities outside the home)	-	30	-	30
<u>Transportation</u>	60	3	5	68